STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155586		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 01/31/2012	
	PROVIDER OR SUPPLIER		STREET A 6701 S	ADDRESS, CITY, STATE, ZIP CODE ANTHONY BLVD WAYNE, IN 46816	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
K0000	and State Licer conducted by to Department of accordance with Survey Date: On 1/31/12 Facility Number Provider Number AIM Number: Surveyor: Amy Code Specialist At this Life Safe Lutheran Life Venot in compliant Requirements: Medicare/Medisubpart 483.70 from Fire and the National Fithe Association (NI Code (LSC), Chell Health Care Octored IAC 16.2.	th 42 CFR 483.70(a). 21/30/12 and 21: 000283 22: 155586 100275020 2 Kelley, Life Safety 2 Kelley, Life Safety 2 Kelley, Life Safety 2 Kelley, Life Safety 3 Kelley, Life Safety 4 Code survey, 2 Kelley, Life Safety 3 Kelley, Life Safety 4 Code survey, 2 Kelley, Life S	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
ANDILAN	or correction	155586	A. BUILDING	01	01/31/2012
			B. WING	ADDRESS, CITY, STATE, ZIP CODE	0 110 1120 12
NAME OF I	PROVIDER OR SUPPLIEF	2		ANTHONY BLVD	
LUTHER	AN LIFE VILLAGES	5		WAYNE, IN 46816	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		be of Type I (332)			
		nd is sprinklered			
	with the excep				
	basement. The				
		building is a one			
	story building	• • • • • • • • • • • • • • • • • • • •			
	construction a	•			
	1 '	he main building			
	has a fire alarn	•			
		on in corridors,			
	· -	the corridors and all			
		s. The Health and			
		building has a fire			
	alarm system v				
		e corridors, areas			
	I	rridors and single			
	=	operated smoke			
		resident rooms			
	1	e wing resident			
		355 and 358 to 364			
	which are occu				
	1	and the Phrenic			
	_	e currently closed. s a capacity of 262			
	I	sus of 131 at the			
	time of this su				
	diffe of tills sur	ıvcy.			
	Quality Review by	Robert Booher, Life Safety			
	Code Specialist-Me	edical Surveyor on 02/09/12.			
	The facility was	s found not in			
	compliance wit				
	aforementione				
	aiorementione	u regulatory			
	I .		ı	<u>I</u>	<u> </u>

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: NQH221

Facility ID: 000283

If continuation sheet Page 2 of 11

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/28/2012 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION AND PLAN OF CORRECTION DESCRIPTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155586		(X2) MULTIPLE CO A. BUILDING B. WING	01	COM 01/3	te survey Ipleted 31/2012	
LUTHER	PROVIDER OR SUPPLIE	S	6701 S	ADDRESS, CITY, STATE, ZIP CO ANTHONY BLVD NAYNE, IN 46816	DDE	E	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
	requirements following:	as evidenced by the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: NQH221

Facility ID: 000283

If continuation sheet

Page 3 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	01	COMPLETED	
		155586	B. WIN			01/31/2012	
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIER			6701 S	ANTHONY BLVD		
LUTHER	AN LIFE VILLAGES	3		FORT \	WAYNE, IN 46816		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE	N
K0018		LSC IDENTIFYING INFORMATION) corridor openings in other	-	TAG	BEI ICEACT)	DATE	
SS=E	than required encl						
00 _	•	hazardous areas are					
		such as those constructed					
		onded core wood, or					
		g fire for at least 20 sprinklered buildings are					
		sist the passage of smoke.					
	There is no imped	iment to the closing of the					
		provided with a means					
		g the door closed. Dutch 3.6.3.6 are permitted.					
	19.3.6.3	5.0.5.0 are permitted.					
		prohibited by CMS					
	1 -	ealth care facilities.	17.00	110	NA/Instrumentalism for		ا ما
	Based on obser		K00)18	What measures were taken for residents directly affected?	or 03/01/201	12
	interview, the f	•			residents directly affected:		
	ensure 1 of 1 s	·			No residents were directly		
	• •	e corridor doors			affected by this deficient practi	ce.	
	closed and latc	hed into the door			What massures were put in		
	frame. This de	ficient practice			What measures were put in place to identify other		
	could affect an	y resident in or			residents at risk?		
	near the Physic	al Therapy room.					
					All residents are at risk to be		
	Findings includ	le:			affected by this deficient practi The physical therapy doors ha		
					been installed in their current	ve	
	Based on obser	vation with the			state for 10+ years with neithe	r	
	Maintenance D	irector and the			incident nor code violation.		
	Maintenance As	ssistant Director on			What avetemic change	4	
	01/30/12 at 1:	50 p.m., the			What systemic change was print place to ensure the deficient		
		by corridor double			practice does not recur?		
İ	I	tching hardware					
		tch into the door			One (1) set of Dorma Model		
		is acknowledged by			8400LB door hardware is bein	· .	
		te Director at the			ordered for the physical therap doors. Installation will occur as		
	time of observa				soon as possible, subject to pa		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: NQH221

Facility ID: 000283

If continuation sheet

Page 4 of 11

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/28/2012 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155586		A. BUILDING B. WING	<u>01</u>	COMPLETED 01/31/2012
	PROVIDER OR SUPPLIER		6701 S	ADDRESS, CITY, STATE, ZIP CODE S ANTHONY BLVD WAYNE, IN 46816	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
TAG	3.1–19(b)	LSC IDENTIFYING INFORMATION)	TAG	and service availability from the third-party contractor. This hardware will latch into the case and provide a panic bar exit device configuration to the laundry doors. All pertinent staff has been in-serviced on this physical plaupdate and the code requirements supporting it. How will the corrective action be monitored? The Director of Maintenance and/or designee will monitor the installation of any new double doors includes the installation properly latching hardware.	ne sing ant ne

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: NQH221

Facility ID: 000283

If continuation sheet

Page 5 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	PLE CONSTRUCTION 01	COM	TE SURVEY IPLETED	
		155586	B. WING		- 01/3	31/2012
	PROVIDER OR SUPPLIER		670	REET ADDRESS, CITY, STATE, ZIP CO 01 S ANTHONY BLVD ORT WAYNE, IN 46816	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	CROSS-REFERENCED TO THE AI	IOULD BE	(X5) COMPLETION DATE
K0029 SS=D	fire-rated doors) of fire extinguishing set. 1 and/or 19.3. areas. When the extinguishing system areas are separate smoke resisting pare self-closing an protective plates the inches from the begarmitted. 19.3. Based on observitem, the fensure the correlaundry rooms, latched into the deficient practice resident in the shop or near the shop or near the findings included and the door frame.	evation and acility failed to ridor doors to 1 of 1 a hazardous area, a door frame. This ce could affect any basement beauty be laundry room. e: eservation with the rector and the sistant Director on 2:23 p.m., both sets ble doors entering om lacked latching lid not latch into . This was the ridor of the maintenance of the rector and lacked latching lid not latch into . This was the Maintenance	K0029	What measures were to residents directly affected by this deficient. What measures were place to identify other residents at risk? All residents are at risk affected by this deficient. Both sets of doors have installed in their current 10+ years with neither in nor code violation. What systemic change in place to ensure the practice does not recurred 10+ years of Dorma	cted? ctly nt practice. put in to be nt practice. e been t state for incident e was put deficient ur? Model are being sets of stallation ossible, rvice rd-party vare will	03/01/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: NQH221

Facility ID: 000283

If continuation sheet

Page 6 of 11

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/28/2012 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155586		A. BUILDING B. WING	<u>01</u>	COMPLETED 01/31/2012
	ROVIDER OR SUPPLIER		6701 S	ADDRESS, CITY, STATE, ZIP CODE ANTHONY BLVD WAYNE, IN 46816	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				a panic bar exit device configuration to the laundry doors.	
				All pertinent staff has been in-serviced on this physical pla update and the code requirements supporting it.	ant
				How will the corrective action be monitored?	n
				The Director of Maintenance and/or designee will monitor the installation of any new double doors includes the installation properly latching hardware.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: NQH221

Facility ID: 000283

If continuation sheet

Page 7 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	01	COMPLE	ETED
		155586	B. WIN			01/31/2	2012
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIER			6701 S	ANTHONY BLVD		
LUTHER	AN LIFE VILLAGES			FORT V	WAYNE, IN 46816		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
K0070 SS=D	except in non-slee	ealing devices are ealth care occupancies, eping staff and employee heating elements of such					
		ceed 212 degrees F. (100					
		rvation, interview iew; the facility	K00	70	What measures were taken for residents directly affected?	or	03/01/2012
		de a policy for the					
	use of 1 of 1 p	·			No residents were directly affected by this deficient practi	ico	
	heaters in the				anected by this delicient practi	ice.	
	accordance wit	•			What measures were put in		
					place to identify other		
		. This deficient			residents at risk?		
	_ ·	in a resident care			All residents are at risk to be		
		affect any number			affected by this deficient practi	ice	
	of staff.				The heating device noted during		
					the survey was in a non-reside		
	Findings includ	de:			care area.		
	Based on an ol	oservation with the			What systemic change was purely in place to ensure the deficie		
	Maintenance D	irector and the			practice does not recur?	111	
	Maintenance A	ssistant Director on			produce describeredar.		
	01/30/12 at 1	2:40 p.m., a space			A policy addressing the use of		
		ise in the Project			portable space heaters in		
		ce located in the			non-resident care areas has b written in accordance with NFF		
		uring the record			101, section 19.7.8.	-A	
		on 01/30/12 at			101,000		
		e facility did not			All pertinent staff has been		
	•	•			in-serviced on this new practic	e.	
		policy regarding the			How will the corrective action	,	
	l .	eaters. Based on			be monitored?		
		the Maintenance					
		ne Maintenance			The Director of Maintenance		
		tor at the time of			and/or designee will monitor a		
	record review a	and then again at			offices on a routine basis weel	kly	
	I		ı		for 12 weeks and monthly		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: NQH221

Facility ID: 000283

If continuation sheet Page 8 of 11

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/28/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION OF CORRECTION 155586	(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED - 01/31/2012
LUTHER	PROVIDER OR SUPPLIER RAN LIFE VILLAGES	6701 S FORT	ADDRESS, CITY, STATE, ZIP CO ANTHONY BLVD WAYNE, IN 46816	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	DULD BE PROPRIATE COMPLETION DATE
	the time of observation, the facility does not have a written policy regarding space heaters and space heaters are not allowed in the facility. 3.1–19(b)		thereafter for quality ass	surance.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: NQH221

Facility ID: 000283

If continuation sheet

Page 9 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DDIC	01	COMPLE	ETED
		155586	B. WIN			01/31/2	2012
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			l	ANTHONY BLVD		
LUTHER	AN LIFE VILLAGES				WAYNE, IN 46816		
			1				
(X4) ID		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	``	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
K0147	Electrical wiring ar		 	IAU			DATE
SS=E		IFPA 70, National					
00-L	Electrical Code. 9	•					
	Based on obser	vation and	K01	47	What measures were taken for	or	03/01/2012
	interview, the f				residents directly affected?		
		vet location resident					
	care areas such				No residents were directly affected by this deficient practi	ice	
		loor lounge was			and cica by this denoterit practi		
	_	ground fault circuit			What measures were put in		
	·	•			place to identify other		
	·	CI) against electric			residents at risk?		
	shock. NFPA 7				All registerate are at right to be		
		cilities, defines wet			All residents are at risk to be affected by this deficient practi	ice	
		tient care areas			All required outlets have been		
	subjected to w	et conditions while			replaced with GFCI outlets.		
	patients are pr	esent. These					
	include standin	ig fluids on the			What systemic change was p		
	floor or drench	ing of the work			in place to ensure the deficie	ent	
	area, either of	which condition is			practice does not recur?		
	intimate to the	patient or staff.			All facility electrical outlets me	et	
	NFPA 70, 517-	20 Wet Locations,			compliance with life safety cod	le.	
	· ·	eptacles and fixed			Any future outlets installed in		
	· ·	nin the area of the			similar areas will be of the ground fault interrupter (GFCI) type.	und	
	wet location to				l ladit interrupter (GPCI) type.		
		oisture can reduce			All pertinent staff has been		
	· ·	istance of the body,			in-serviced on this new practic	e.	
		• •					
		nsulation is more			How will the corrective action be monitored?	n	
	-	re. This deficient			ne monitorea?		
	·	affect any resident			The Director of Maintenance		
	in the third floo	or lounge.			and/or designee will monitor th		
					installation of any new electric		
	Findings includ	le:			outlets to ensure the GFCI typ installed.	e is	
					installed.		
	Based on obser	vation with the					
	Maintenance D	irector and the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: NQH221

Facility ID: 000283

If continuation sheet Page 10 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPLE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155586		LDING	01	01/31/2	
		100000	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	01/01/2	
NAME OF P	PROVIDER OR SUPPLIEF	2			ANTHONY BLVD		
LUTHER	AN LIFE VILLAGES				VAYNE, IN 46816		
(X4) ID				ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	·	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	TE	COMPLETION DATE
		ssistant Director on					
		:00 p.m., the main					
		floor lounge had an					
		tacle on the wall					
		et of a sink which					
	was not provid	ed with GFCI					
	protection to p	revent electric					
		ested with a GFCI					
	_	the circuit was not					
	· ·	his was confirmed					
	by the Mainten						
	Director at the	time of					
	observation.						
	2 1 10/b)						
	3.1-19(b)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: NQH221

Facility ID: 000283

If continuation sheet

Page 11 of 11